

NH MEDICAL CONTROL BOARD

Richard Flynn Fire Academy
222 Sheep Davis Road
Concord, NH

15 January, 2004

MINUTES

Members Present: Doug McVicar, MD, Sue Prentiss, Bureau Chief, Jeff Johnson, MD, Joseph Mastromarino, MD, William Siegart, MD, Joseph Sabato, MD, Jim Martin, MD, Norman Yanofsky, MD, Mary Valvano, MD,

Members Absent: Frank Hubbell, DO, Chris Fore, MD, John Sutton, MD.

Guests: Donna Clark, Tom D'Aprix, MD, Fran Dupruis, Tom Andrew, MD, Dave Hogan, Doug Martin, John Sanders, Jeanne Erickson, Fred Heinrich, Stephanie Dornsife, Dennis Ireland, Dave Dube, Janet Houston

Bureau Staff: Kathy Doolan, Field Services Coordinator; Will Owen, Assistant ALS Coordinator; John Clark, ALS Coordinator

I. CALL TO ORDER

Item 1. The meeting of the EMS Medical Control Board was called to order by Dr. McVicar at 0912h.
Item 2. Review of agenda and introductions.

II. ACCEPTANCE OF MINUTES

Presentation of Minutes by McVicar. No additions, deletions or corrections. Motion to accept by Mastromarino. Second by Sabato. Approved by voice vote.

II. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

Item 1. ACEP Report – Sabato. ACEP is holding a snow day. More info on the ACEP website. Three areas of the state have received grants to improve volunteers outside of the hospital. Derry, Nashua and the North Country. Meeting to discuss these grants and get started on 30 January.

Item 2. Introduction of John Clark as new ALS Coordinator – Prentiss. John Clark to fill vacancy created by Will Owen's departure. Introduction by Prentiss of Clark. He graduated with a JD from Franklin Pierce Law Center in Concord, NH in May and comes to the Bureau with a solid background in health care delivery and health care administration. He has had clinical experience in settings as varied as emergency departments to supervisor and preceptor roles in a fire department based EMS system as well as critical care transport in both ground and flight environments. Beyond his clinical qualifications, he has extensive knowledge and expertise in developing, coordinating, and presenting education programs for all levels of health care providers. As a flight program director, he created and managed annual budgets in excess of \$1.5 million and successfully led an international professional association (the National Flight Paramedics Association). Additionally, he has consulted for hospitals and EMS services on educational issues, system design and resource utilization and co-authored a textbook on pediatric emergency care and contributed chapters to several others as well as having published numerous articles related to emergency care and is frequently invited to speak at local and national EMS meetings and conferences. He sits on the National Registry of EMTs Board of Directors and is the first person from New Hampshire to hold this position.

Item 3. Bureau Report – Prentiss. See attached report for full text. Deployed active duty military will be allowed a 90 day window after return to complete NREMT Rereg requirements. The Bureau will provide as much assistance as possible to ensure that they can remain current.

Item 4. Division Report – Mason. Dedicated Funding is not coming in as fast as last year. Last year there was a budget surplus and this year the Division is covering half of OEM and the FM. The possibility exists that the Division could be asked to cut 10% as other agencies, however that would require legislative action because dedicated funds cannot be used elsewhere. Starting 1 July, the bond for the new dormitory will become due and payments will start.

Two senate bills are there; SB380 says that the commissioner may through rules implement a statewide incident command system. Right now, the current legislation allows for statewide ICS for hazmat. In FY05, grant eligibility will rely on those towns having a formal ICS program in place. Heard in committee yesterday and will go forward. Bill should go to the house by then end of the month.

SB432 solidifies the current relationship within the Division and makes the name change to reflect EMS inclusion in FS&T. The NHEMT Association expressed concerns with the name change and the committee agreed to consider those concerns. The goal is align emergency communication and take the Fire Marshall's office out as a stand alone and then to change the name of FS&T to include EMS. The senate asked that the NH EMT Association and the Division meet to resolve concerns. Personal concerns expressed that Mason's son being shipped to Iraq.

Item 5. EMS Medical Director's Roundtable and Dinner – McVicar. Review of November '03 "First Annual NH EMS Medical Director's Roundtable & Dinner" presented. The purpose of the meeting was to get together with EMS Medical Directors from those NH hospitals – approximately 50% -- without a representative on the MCB. Because of a storm travel conditions were poor and the turn out was less than we hoped for. Thirteen hospitals were represented (Weeks, Monadnock, Speare, Dartmouth, Frisbee, Portsmouth, Southern New Hampshire, St Joseph's, Valley Regional, Lakes Region, Franklin, Huggins, Elliot). Medical Directors from hospitals without an MCB member reported that the MCB is working well for them, and approved of the recent changes made in the protocols process, including the standardized two-year cycle

Specific issues facing the MCB during this protocol cycle were discussed, and in some cases voted on using a quantitative evaluation of consensus. The group would like more opportunity for discussion of EMS issues, and suggested an EMS Medical Director's listserve. Several hospitals have had problems concerning apparently uninjured minors who wish to sign off at the scene of an accident. There is general agreement that NHBEMS should develop a protocol for refusal of care by minors that is consistent statewide and supported by legal research. The TEMSIS project was well received, and the group supports using data wherever possible to create evidence-based policy. The group unanimously supported changing the Transfer Protocols to allow the use of approved medications in ways not allowed in the protocols when so ordered by the transferring physician and given certain safeguards. There was strong support for increasing the consistency of protocols statewide, even if it meant removing protocols from the category of local option.

Item 6. Intersections Initiative – Sabato. December 3, initial training program. Thanks to the FST for hosting the program. So People May Live was remote broadcast to Littleton who will do a helmet program. 14 Jan was the first day of the core program with 11 students. The idea is to combine EMS and public health to develop prevention programs.

Working on a follow-up to the impaired driving summit that was held last year. Also a potential public health cardiac workshop. Also, looking at a CDC grant to support the Enhanced EMS training.

Item 7. ME Shared Interest with EMS – Andrew. The role of the ME's office is to examine the small handful of the 25 statutory causes of death. Views the office as more public health than law enforcement and the public health focus is where the broadest intersection with EMS. Data collection and sharing with

EMS is useful to both areas. Several areas that already exist are pediatric death and teen suicide. Some of this material is publishable and one area of interest is snowmobile deaths – other areas may be useful in shaping policy. The basic message is that the ME's office is happy to share their info and are specifically exempted from HIPAA laws that encourages this type of sharing.

Question from McVicar about the ability to search for specific data. The answer is that much of the data is not centralized and much is still on paper. It is improved, but still somewhat burdensome. Limited federal money is available to improve electronic management of the data. Movement is slow, but is improving, however that should not dissuade anyone from requesting data.

Question from Houston about pediatric death committee. A broad group of 30 – 35 people who deal with child fatalities including judges, lawyers, social workers, EMS, physicians, public health workers, teachers, etc. They meet every other month to review one or two child fatalities to identify preventability factors and to see if there is public education that may prevent similar deaths. It is not an inquisition, but more of a review to create recommendations for an annual report to the governor or the AG at the annual child abuse and neglect conference.

Question from McVicar regarding the training of EMS investigators and asked about the level of certification necessary as a prerequisite for training as an ME investigator. Training and certification to paramedics is possible. An annual training program for 6 – 10 people has been offered. The greatest deficit is the west side of the North Country and investigators are needed there. One solution is to create a distance learning program using CD-ROM based education. A new staff person will be on board in the spring and will move that education forward.

A second concern by McVicar is that EMS units are being held at call waiting for an investigator. The answer is that there are areas that response time for an investigator are long and that there are holes in the state for coverage and that the ME's office will work to resolve those issues.

Johnson advised that they are affected by the lack of investigators in Lancaster. Starting next year, paramedic coverage will be available 12 hours a day from the ED and may be able to train those paramedics to be investigators. Andrew asked about grant money to address distribution of materials that may be available from the Lancaster program.

Heinrich asked about why it is EMS's role and not police. Uncertain who or if there is a legal requirement that anyone needs to stay. Various discussions about several experiences in areas of state (Hogan – Keene, Johnson – Colebrook, Johnson – Vermont experience).

Hogan asked about mechanism to obtain cause and manner of death. Providers can call the ME's office and they will be provided with cause and manner. Sometimes final answers are delayed, since 40 – 50 % leave the autopsy room with a "pending" determination due to need for additional info (e.g. tox screen results).

Item 8. E911 Report – Wood. EMD has hired Bill Finch part-time to handle EMD call review. Calls are randomly selected for review. Finch comes from Medical Priority Dispatching and has relocated to southern New Hampshire. L'Heureux is the contact point to request a review of a specific request.

Lost calls from mobile and unknown locations for cell callers is a caller. All cellular carriers must direct 911 callers to 911 rather than alternative seven digit numbers. Average time to manage a cell call is 3 minutes rather than a hardwired call that presents ANI-ALI info. E911 averages 1900 calls a day.

2004 compliance with cellular providers that will give E911 the number and the cell tower that the call originates from to help narrow the location of the incident.

Albertson asked about GPS tracking of phones and what NH is looking to do and who pressure can be placed on to change the data mandated. Wood's answer was that E911 has the capability to display data

anyway that the cellular provider provides. This is an FCC issue and the deadline that keeps being extended and currently the deadline is 2007.

Mapping has been streamlined and E911 is working with towns to improve interface. Generally 40% of towns are mapped.

Albertson asked about need for hardware/software to improve mass casualty responses and will those enhancements be included in the new EOC construction project. Wood responded that there are automation systems being examined and that many systems will be shared to improve efficiency.

Heinrich asked about review of license for EMD and what is the timeline. L'Heureux is working with Director Mason and it's in legal now.

III. DISCUSSION & ACTION PROJECTS

Item 1. Local Option & Statewide Protocols – McVicar. Legislation to create a simplified process for adopting protocols as rule (“fast track”) was withdrawn by the Department of Safety for this year. McVicar noted that this does not change the MCB’s fundamental commitment to increase standardization of protocols throughout the state. However it means that method used will be different. For this protocol cycle at least, the plan to move protocols out of local option and into rules, becomes impractical. We will need to use the framework of Local Option, which is certainly do-able.

Discussion by the group about what the impact will have on the protocol process. Yanofsky offered that we need to make sure that the changes happen, and that in some cases we may need to move protocols *out* of rule and *into* local option.

Prentiss advised that there will have to be rule change to allow for necessary changes in the Statewide (primarily ACLS) Protocols already in rule, and the Bureau will continue to work with the community and the legislature to make those changes according to the existing process.

Owen opined that the process must continue to move forward and not allow the legislative setback to hold up the process. The door to the needed legislation is not permanently closed, but a consensus needs to be established first.

Heinrich asked how the changes will affect local option versus statewide protocols. McVicar stated that for this two year cycle it means more Local Option protocols and fewer statewide protocols. Prentiss noted that the current legislative wording establishing Local Option will allow for introduction of new protocols keeping in mind the limitation of the “minimum/maximum menu”. Therefore the Bureau is confident that the content review and revision can continue to move forward.

Item 2. Protocol Content Review/ALS Task Force – Owen/Albertson. Overview of proposed changes from Protocol 1.1 to 2.7. McVicar asked a question of the group about the use of changes in pressor agents. Lanzetta addressed question about changes in literature and research. D. Martin weighed in advising that some changes also addressed local practice.

Item 3. Proposal to change interfacility transfer guidelines – Owen. Discussion at the last meeting about the interfacility medication list and wording of policy. The group was provided with current and proposed language. Owen presented short .ppt about the changes to review the wording. Discussion by D’Aprix about the potential advantages of including a broad class of antibiotics rather than individually identifying single agents for the approved drug list. Discussion by the group that there may be value in this, but that such a change would need to be implemented by the protocol subcommittee to make the change uniformly to the entire interfacility protocols. Additional note made that a change to include new classes of drugs needs to go through the Board of Pharmacy. McVicar said he would raise with the Board of Pharmacy the issue of identifying approved drugs by class rather than individually. Motion made by Yanofsky seconded by Mastromarino to accept Owen’s proposal as worded. Unanimous agreement.

Item 4. Proposal to include Levalbuterol on Approved Drug List – Mastromarino/D. Martin.

Discussion by Mastromarino of the historical perspective and the research behind the suggestion for the addition of levalbuterol to the approved drug list. Further support and comment by D. Martin. Lanzetta shared his hospital's experience in support of the change as well. McVicar called for survey of practice in their own emergency departments – group was approximately evenly split on use. Motion made by Mastromarino seconded by Lanzetta to accept inclusion of Levalbuterol to the 2005 protocol revision approved drug list. Unanimous agreement.

Further discussion after the vote concerning the benefit of fast tracking the change and submitting it to the Board of Pharmacy now, rather than just including it in the edition of protocols currently being constructed. Discussion between McVicar and Mastromarino regarding the need to move the change along more quickly. Lanzetta also weighed in on the need to do this more urgently. Yanofsky and McVicar made the argument that since the currently available agent works well and has proven very safe, and since the literature supporting Levalbuterol at best shows minimal advantages, there is not enough urgency to move it forward on a fast track before the 2005 protocol revision. Yanofsky pointed out that discussing individual agents on a piecemeal basis may be out of order. The Board of Pharmacy probably would rather receive the whole updated drug list that supports the 2005 protocol revision at one time. Motion made by Albertson seconded by Mastromarino: "Approve the implementation of Xopenex as an option, as soon as reasonably possible, not as an emergency, but at the discretion of the board to roll this out with all deliberate speed." Divided vote: 6 for – 2 against. Motion carries.

IV. ADJOURNMENT

Motion made by Albertson seconded by Mastromarino to adjourn. Unanimous agreement for adjournment at 1227h.

V. NEXT MEETING

Next meeting Thursday, March 18, 2004 at 0900h the Richard Flynn Fire Academy in Concord, NH.

Respectfully submitted,

Suzanne M. Prentiss, BS, NREMT-P
Bureau Chief, EMS